



Child Care Scholarship 2009 Application

Riley County Smart Start & the Early Childhood Block Grant have an opportunity to improve the affordability of quality child care. The scholarship program allows parents the opportunity to receive financial assistance for Child Care if their licensed child care provider participates in the Raising Riley Smart Start Program. Raising Riley Smart Start and the Riley County-Manhattan Health Department do not discriminate based on race, color, national origin, gender, age, disability, political beliefs, sexual orientation, religion and marital or family status. All information contained in this application is strictly confidential.

To Be Considered for a Scholarship:

- ☐ You must live or work in Riley County, Kansas.
- ☐ You must have a child who is birth through five years old (not yet in kindergarten).
- ☐ Your child must be ENROLLED with a licensed provider that participates in the Raising Riley Smart Start Program.
- ☐ Your child may not receive financial assistance with child care exceeding ½ of the total cost of tuition.
- ☐ You must meet the income guidelines on page 4 of the application.
- ☐ You agree to completing a one-time developmental screening within 1 year of the date your child is awarded a scholarship.
- ☐ You agree to participate in surveys for grant evaluation.
- ☐ Your application must be completed and all supporting documentation must be returned in with it.

CHILD'S INFORMATION (Scholarship Recipient)

Child's Name: _____ Date of Birth: _____
Last First MI

Address: _____ Gender: Male Female
Street City Zip

How long has child lived at the address above? Race: _____
_____ 12 months or more _____ American Indian or Alaskan Native
_____ Child has lived at multiple addresses during the _____ Asian or Pacific Islander
preceding 12 months _____ Black, not of Hispanic origin
_____ Child does not have a stable residence or home _____ Hispanic
_____ White, Not of Hispanic origin
_____ Other: _____

Child lives with : _____ Both parents (Mother/Father) _____ Mother only _____ Father only
_____ Other family members or guardian _____ Other (Please explain _____)

What is your family's primary language? _____

CHILD CARE PROVIDER/CENTER INFORMATION

Child Care Provider or Center Name: _____

Address: _____ Phone: _____
Street City Zip

What is the MONTHLY amount you pay for child care for THIS child? \$ _____

What is the MONTHLY amount you pay for child care for ALL children? \$ _____

Does your child have or do you suspect your child has a developmental delay, disability or health condition? _____
If yes, describe: _____

Does child have: _____ Individualized Family Service Plan (IFSP) _____ Individualized Education Plan (IEP)

Does child have: _____ Health Insurance _____ Medicaid _____ Access to a pediatrician or family doctor



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PARENT/GUARDIAN #1 INFORMATION (Primary Contact)

Name: _____ Date of Birth: _____
Last First MI

Address: _____ Phone: _____
Street City Zip

Marital Status: _____ Race: _____

Email Address: _____

Have you recently experienced a family emergency or have an individual need we should take into consideration?
(i.e., sudden loss of job, sudden/severe illness) ____ No ____ Yes (Please explain): _____

EDUCATION: ____ GED ____ High School Diploma ____ Some College ____ AA/AS Degree
(Check all that apply) ____ BA/BS Degree ____ Graduate Degree ____ Currently a Student* ____ Other _____

*** Must attach copy of official class schedule for each semester during scholarship**

EMPLOYMENT

Job #1

Employer: _____ Job Title: _____

Supervisor's Name: _____ Phone: _____

Hire Date: _____ Hourly wage: \$ _____ Average hours worked per week: _____

Job #2

Employer: _____ Job Title: _____

Supervisor's Name: _____ Phone: _____

Hire Date: _____ Hourly wage: \$ _____ Average hours worked per week: _____

PARENT/GUARDIAN #2 INFORMATION (If Applicable)

Name: _____ Date of Birth: _____
Last First MI

Address: _____ Phone: _____
Street City Zip

Marital Status: _____ Race: _____

EDUCATION: ____ GED ____ High School Diploma ____ Some College ____ AA/AS Degree
(Check all that apply) ____ BA/BS Degree ____ Graduate Degree ____ Currently a Student* ____ Other _____

*** Must attach copy of official class schedule for each semester during scholarship**

EMPLOYMENT

Job #1

Employer: _____ Job Title: _____

Supervisor's Name: _____ Phone: _____

Hire Date: _____ Hourly wage: \$ _____ Average hours worked per week: _____

Job #2

Employer: _____ Job Title: _____

Supervisor's Name: _____ Phone: _____

Hire Date: _____ Hourly wage: \$ _____ Average hours worked per week: _____



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HOUSEHOLD/INCOME INFORMATION Note: List everyone who lives in your home, including roomers, boarders, friends, relatives and yourself. You must list all sources of income for each adult in the household. If you need more room, please attach a separate sheet of paper listing the additional information. *A description of the type of income to report in this section can be found on **page 5**.

Name	Relation-ship	Date of Birth	*Type of income	Employer	Hourly Wage	Total hours worked weekly	Total hours worked monthly	Gross Monthly Income
TOTAL MONTHLY INCOME (include all adults in household)								\$

OTHER INCOME

Does your family RECEIVE or QUALIFY for any of the following?	Yes	No	Amt Received Monthly
Child Support			
Army Child Care in Your Neighborhood			
Food Stamps			
SRS Child Care Subsidy—Voc-Rehab			
SRS Child Care Subsidy—Heartland Works			
SRS Child Care Subsidy			
Aid to Families With Dependent Children			
Health Wave			
WIC			
Any other assistance with child care? If yes, explain_____			

Do you qualify for the SRS child care subsidy based on income, but are ineligible based on student status? ____ Yes ____ No

REQUIRED: Please provide us with your most recent 2 months of income verification (pay stubs).



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INCOME INFORMATION

The following are sources of income which must be counted when determining eligibility for child care services:

1. Gross earned wages of salary (earnings received for work performed as an employee, including wages, salary, commissions, tips, piece-rate payments, and cash bonuses earned, before any deductions are made for taxes)
2. Adjusted gross income from taxable self-employment income
3. Social Security Benefits (includes social security pensions, survivors' benefits for both children and adults, and permanent disability insurance payments)
4. Workers' compensation
5. Unemployment insurance benefits (UIB)
6. Alimony (includes court ordered payments as well as voluntary payments and may include regular payment of bills such as rent and utilities)
7. Child support, direct or indirect (includes payments made to the parent or to the court based on terms of an agreement and may include payments such as rent, utilities, insurance, etc.)
8. On-the-Job Training (OJT) payments
9. Armed Forces pay (only the amount taxable, such as base pay)
10. Recurring cash contributions paid directly to the parent/responsible adult

The following are sources of income which are not counted when determining eligibility for child care services:

1. Supplemental Security Income (SSI)
2. Foster care and adoption assistance payments
3. Money borrowed
4. Tax refunds
5. Gifts or contributions (These are non-recurring gifts or contributions, e.g. gifts for birthdays, holidays, occasional monetary contributions, purchase of diapers, clothing, etc.)
6. Loans, grants (including Pell or Carl Perkins grants), scholarships, and money received through job training programs

2009 HHS Poverty Guidelines Raising Riley Child Care Scholarships are based on 200% of poverty

Size of Family Unit	200 Percent of Poverty
1	\$21,660
2	\$29,140
3	\$36,620
4	\$44,100
5	\$51,580
6	\$59,060
7	\$66,540
8	\$74,020



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Child Care Enrollment & Fee Verification Form

This form is to be COMPLETED BY THE DIRECTOR OF THE CHILD CARE CENTER OR THE CHILD CARE PROVIDER and returned with the completed application. This form is to confirm that your child is enrolled in full-time care and to verify the current monthly rate you pay for child care for this child.

Child's Name: _____

Name of Center/Provider: _____

Center/Provider Address: _____

Provider Phone#: _____ Provider
Email: _____

(Do you check your email regularly? ☐ Yes ☐ No)

Is child enrolled in full-time care now? ☐ Yes ☐ No Start Date: _____ End Date: _____

Is your center/child care home licensed? ☐ Yes ☐ No Are you currently participating in Smart Start? ☐ Yes ☐ No

What is the monthly rate applicant pays for child care for this child? \$ _____

NOTICE TO PROVIDERS: Please submit your Child Care Reimbursement Form (available at www.raisingriley.org) to the Riley County-Manhattan Health Department a month in advance. Example: To receive payment for the month of February, you must submit your reimbursement form for the month of February by January 31st. Checks will be cut at the end of February.

Child Care Center or Home Provider Responsibilities:

- Complete and return 2009 Raising Riley Smart Start Provider Enrollment Form
- Complete and return 2009 Raising Riley Child Care Scholarship Reimbursement Form

I certify that the information listed above is accurate to the best of my knowledge and that this child is enrolled in care on a full-time basis. I also understand that it is my responsibility to notify Smart Start of any changes in child care with this child.

Signature of Center Director or Licensed Family Child Care Provider

Date

Raising Riley Child Care Scholarship Program
Family & Child Resource Center
2101 Claflin Road, Manhattan, KS 66502
Contact: Nanette Stark
Phone: (785) 776.4779 x 303 Email: nstark@rileycountyks.gov
Raising Riley Website: www.raisingriley.org